Employment Development Department

State of California

Health and Human Services Agency

APPLICATION FOR DISABILITY INSURANCE ELECTIVE COVERAGE

Complete this application only if you meet the requirements as set forth in the attached Information Concerning Elective Coverage.

**The disclosure of your Social Security Account Number is mandatory under the Federal Tax Reform Act of 1976.*

NOTE: If you require any assistance in the completion of this application, contact the nearest Employment Tax Customer Service Office of this Department, or call (916) 464-2500. Upon completion of the application, return to: Employment Development Department, FACD Central Operations, MIC 94, 10969 Trade Center Drive, Suite 203, Rancho Cordova, CA 95670-6140.

FOR DEPARTMENT USE ONLY			
APPROVED: ☐ 708(b) ☐ 708.5	DIEC ACCOUNT #		
EFFECTIVE DATE	SUBJECT QUARTER		
SEND FORMS DE 2515, DE 3816DI, DE 5137, ☐ DE 3DI QTR(S) _____			
DATE FORMS SENT	CLASSIFIED BY	DATE	

PLEASE TYPE OR PRINT ALL INFORMATION CLEARLY

1. SOCIAL SECURITY NUMBER* ___ – ___ – ____

2. CALIF. EMPLOYER ACCOUNT NUMBER ___ – ___ – ___ – ____

3. SEX ☐ MALE ☐ FEMALE YEAR OF BIRTH

4. YOUR NAME FIRST MIDDLE INITIAL LAST

5. HAVE YOU APPLIED FOR ELECTIVE COVERAGE BEFORE? ☐ YES ☐ NO IF YES, ____ MO ____ YR.

6. MAILING ADDRESS: NUMBER OR P.O. BOX, STREET CITY ZIP CODE

7. BUSINESS NAME (IF ANY) BUSINESS TELEPHONE ( )

8. BUSINESS ADDRESS: NUMBER OR P.O. BOX, STREET CITY ZIP CODE

9. EMAIL ADDRESS:

10. WEB PAGE ADDRESS:

11. DO YOU HAVE ANY EMPLOYEES? ☐ YES ☐ NO
IF YES, AND YOU ARE NOT REGISTERED WITH THIS DEPARTMENT AS AN EMPLOYER, PLEASE EXPLAIN:

12. TYPE OF ORGANIZATION:
☐ CORPORATION - DO NOT SUBMIT, CORPORATE OFFICERS ARE EMPLOYEES AND COVERED UNDER THE STATE DISABILITY INSURANCE PROGRAM.
☐ GENERAL PARTNERSHIP (INCLUDES HUSBAND AND WIFE CO-OWNERS WHO ARE BOTH ACTIVE IN THE OPERATION AND MANAGEMENT OF THE BUSINESS).
☐ INDIVIDUAL ☐ LIMITED PARTNERSHIP - ONLY GENERAL PARTNER MAY APPLY

13. NAME(S) AND TITLE OF ALL PARTNERS (CONTINUE ON ANOTHER PAGE IF NECESSARY)

GENERAL PARTNERS	Social Security Number*	LIMITED PARTNERS	Social Security Number*

14. NATURE OF BUSINESS:
☐ CONTRACTING ☐ MANUFACTURING ☐ REPAIRING
☐ RETAIL TRADE ☐ SERVICE ☐ WHOLESALE TRADE ☐ OTHER (DESCRIBE)

15. YOUR OCCUPATION/TITLE

16. DESCRIBE THE TYPE OF SERVICE, TYPE OF CONTRACTING, OR PRODUCT SOLD.

17. IS A LICENSE OR PERMIT REQUIRED IN YOUR TRADE, BUSINESS OR OCCUPATION? ☐ YES ☐ NO IF YES, INDICATE TYPE OF LICENSE OR PERMIT REQUIRED:
DO YOU POSSESS SUCH A VALID AND ACTIVE LICENSE? ☐ YES ☐ NO
PROVIDE LICENSE/PERMIT NUMBER

18. ARE YOU CONDUCTING A SEASONAL TYPE OF BUSINESS?
☐ YES ☐ NO IF YES, DO NOT SUBMIT, YOU ARE NOT ELIGIBLE FOR THIS COVERAGE. SEE INFORMATION SHEET ATTACHED.

19. DO YOU EXPECT TO REMAIN IN BUSINESS FOR THE NEXT EIGHT (8) CALENDAR QUARTERS?
☐ YES ☐ NO IF NO, DO NOT SUBMIT, YOU ARE NOT ELIGIBLE FOR THIS COVERAGE. SEE INFORMATION SHEET ATTACHED.

20. DO YOU PERFORM SERVICES IN YOUR TRADE, BUSINESS, OR OCCUPATION CONTINUOUSLY THROUGHOUT THE YEAR? (INCLUDE TIME SPENT DOING OFFICE WORK, SOLICITING CUSTOMERS AND MAINTAINING MACHINERY AND EQUIPMENT.)
☐ YES ☐ NO
IF NO, EXPLAIN.

21. HOW LONG HAVE YOU PERFORMED SERVICES AS A SELF-EMPLOYED INDIVIDUAL OR PARTNER? _____ YEAR(S) _____ MONTH(S)

IF LESS THAN 1 YEAR, GIVE DATE BUSINESS STARTED _____ / _____ / _____

22. DO YOU PERFORM YOUR SERVICES UNDER A WRITTEN CONTRACT OR AGREEMENT?

☐ YES (PLEASE ATTACH COPY) OR (EXPLAIN ORAL AGREEMENT IN #31)

☐ NO

23. IS THE MAJOR PART OF YOUR SERVICE(S) PERFORMED FOR ANY SPECIFIC FIRM OR INDIVIDUAL?

☐ YES ☐ NO

IF YES, IDENTIFY THE BUSINESS NAME AND ADDRESS.

24. HAVE YOU PREVIOUSLY WORKED AS AN EMPLOYEE FOR A FIRM FOR WHICH YOU ARE NOW PERFORMING SERVICES?

☐ YES ☐ NO

IF YES, EXPLAIN SERVICES PERFORMED AS AN EMPLOYEE.

25. IF YOU ARE SELF-EMPLOYED, AND ALSO AN EMPLOYEE, DO YOU RECEIVE THE MAJOR PART OF YOUR REMUNERATION FROM YOUR SELF-EMPLOYMENT?

☐ YES IF YES, WHAT PERCENTAGE? _____%

☐ NO IF NO, EXPLAIN MAJOR SOURCE OF REMUNERATION.

26. IF YOU WERE SELF-EMPLOYED DURING THE LAST TWO YEARS, WHAT WAS YOUR NET PROFIT AS SHOWN ON YOUR IRS SCHEDULE SE, LINE 3?

_____ $ _____ _____ $ _____

YEAR NET PROFIT YEAR NET PROFIT

IF YOU HAVE NEVER FILED A SCHEDULE SE WITH THE IRS DID YOU HAVE NET PROFIT IN EXCESS OF $4,600 LAST YEAR?

☐ YES ☐ NO

IF YOU HAVE BEEN IN BUSINESS FOR LESS THAN ONE YEAR, DID YOUR AVERAGE NET PROFIT EXCEED $1,150 PER QUARTER?

☐ YES ☐ NO

IF YOU JUST STARTED A BUSINESS, DO YOU EXPECT TO EARN A NET PROFIT OF AT LEAST $1150 PER QUARTER THROUGH THE END OF THE YEAR?

☐ YES ☐ NO

PLEASE SUBMIT COPIES OF YOUR IRS SCHEDULE SE FOR THE LAST TWO YEARS. IF ONLY IN BUSINESS ONE YEAR, ENTER ZERO FOR THE OTHER YEAR.

IF YOU ANSWERED NO TO ALL THREE QUESTIONS, DO NOT SUBMIT THIS APPLICATION UNTIL YOU EARN THE REQUIRED MINIMUM NET PROFIT IN YOUR TRADE, BUSINESS, OR OCCUPATION.

27. WERE YOU CONVICTED OF A MISDEMEANOR UNDER THE UNEMPLOYMENT INSURANCE CODE DURING THE LAST EIGHT (8) CALENDAR QUARTERS? (SEE ATTACHED INFORMATION SHEET)

☐ YES ☐ NO

28. DO YOU PRESENTLY HAVE AN ILLNESS OR DISABILITY WHICH PREVENTS YOU FROM CURRENTLY PERFORMING ALL YOUR REGULAR AND CUSTOMARY SERVICES IN CONNECTION WITH YOUR TRADE, BUSINESS OR OCCUPATION?

☐ YES ☐ NO IF YES, DID YOU FILE A CLAIM FOR BENEFITS?

29. HAVE YOU BEEN DISABLED DURING THE LAST THREE MONTHS?	IF YES, DID YOU FILE A CLAIM FOR BENEFITS?	WHEN DID YOU RESUME YOUR USUAL DUTIES? (DO NOT FILE APPLICATION IF YOU ARE CURRENTLY DISABLED.)
☐ YES ☐ NO	☐ YES ☐ NO	_____ / _____ / _____

30. ON WHAT DATE DO YOU WISH ELECTIVE COVERAGE TO COMMENCE? KEEP IN MIND THAT THE COMMENCEMENT DATE OF AN ELECTIVE COVERAGE AGREEMENT SHALL NOT BE PRIOR TO THE FIRST DAY OF THE CALENDAR QUARTER IN WHICH THE APPLICATION IS FILED, NOR LATER THAN THE FIRST DAY OF THE FOLLOWING CALENDAR QUARTER.

☐ FIRST DAY OF CURRENT QUARTER ☐ DAY BUSINESS STARTED (SEE ITEM #21 ABOVE) ☐ FIRST DAY OF NEXT QUARTER

31. ADDITIONAL INFORMATION (USE THIS SPACE TO MORE FULLY DISCUSS THE ABOVE QUESTIONS)

NOTE: *DO NOT SEND PAYMENT WITH THIS APPLICATION. YOU WILL BE NOTIFIED WHEN PAYMENT IS DUE. THIS IS AN APPLICATION FOR COVERAGE NOT A REQUEST FOR INFORMATION. IF YOU NEED ADDITIONAL INFORMATION, PLEASE SEE THE NOTE ON THE FRONT OF THIS FORM. IF YOU ARE ILLEGALLY IN THE UNITED STATES, YOU ARE NOT ELIGIBLE FOR BENEFITS AND ARE LIABLE TO REPAY ANY BENEFITS PAID TO YOU.*

DECLARATION

I, the undersigned, declare that the statements made on this application are true and correct to my best knowledge and belief. I understand that providing false information will result in denial or termination of coverage. I hereby elect and make application to have my services considered as employment subject to the California Unemployment Insurance Code for disability insurance only. I hereby authorize the verification of any information provided by me on this application. I understand that this election must remain in effect for two complete calendar years unless I no longer meet all of the eligibility requirements of Section 704 of the California Unemployment Insurance Code or I meet the conditions for termination of coverage under Section 704.1 of the Code.

SIGNATURE OF APPLICANT DATE

RESIDENCE ADDRESS (NUMBER OF P.O. BOX, STREET, CITY, AND ZIP CODE) RESIDENCE TELEPHONE

( )

APPLICATION MUST BE SIGNED TO BE VALID.

INFORMATION CONCERNING DISABILITY INSURANCE ELECTIVE COVERAGE (DIEC) UNDER SECTIONS 708(b) AND 708.5 OF THE CALIFORNIA UNEMPLOYMENT INSURANCE CODE (CUIC)

Do not send any payment with this application. Contributions are not payable in advance.

You will receive a written notice of the approval or denial of your application.

If your elective coverage agreement is approved, instructions will be sent to you for filing your returns and paying the premiums due. Your agreement is subject to the requirements and conditions outlined below.

PLEASE RETAIN THIS PAGE FOR REFERENCE.

PERSONS ELIGIBLE TO ELECT COVERAGE

- Self-employed individuals who receive the major portion of their remuneration from the trade, business or occupation in which they are self-employed. (CUIC Section 708.5). Annual net profit must be at least $4,600 or average $1,150 per quarter if in business for less than one year.
- An individual who is an employer under Section 675 of the Code, or two or more individuals (general partners) who have so qualified. (CUIC Section 708(b)). Each individual who applies must meet the minimum net profit requirements discussed in the previous paragraph.

Individual proprietors and general partners are eligible to apply for coverage. (It is not required that all active general partners be included in the election.) An active general partnership also includes a husband and wife co-ownership in which both spouses are active in the operation and management of the business. Limited partners and corporate officers are considered to be employees subject to the compulsory provisions of the Code, the same as all other employees, and are not eligible to elect self-coverage.

CONDITIONS FOR DENIAL OF COVERAGE

Section 704 provides that an election under Section 708(b) or Section 708.5 shall not be approved if it is found that any of the following conditions exist:

(a) The self-employed individual is currently unable to perform his or her regular and customary work due to injury or illness. (If you are currently disabled and unable to perform all of your regular and customary services, you must wait until you recover from your disability before you can elect coverage.)

(b) The employing unit or self-employed individual is ***not*** normally and continuously engaged in a regular trade, business or occupation. Normally and continuously engaged in a regular trade, business or occupation means to be regularly performing services and engaged in an uninterrupted pattern of work, which is customary for the trade or business.

If you regularly work less than the normal customary full-time hours typical for your industry or trade, you are ***not*** normally and continuously engaged in a regular trade, business or occupation. Self-employment hours include time spent doing office work, soliciting customers and maintaining machinery/equipment.

A self-employed individual or individual who is an employer in a trade, business or occupation that requires a valid and active license and does not possess such a license is ***not*** normally and continuously engaged in a regular trade, business or occupation.

(c) The employing unit or self-employed individual intends to discontinue the regular trade, business or occupation within eight calendar quarters.

(d) The regular trade, business or occupation of the employing unit or self-employed individual is seasonal in its operations.

(e) The major portion of the self-employed individuals remuneration is not derived from his or her trade, business, or occupation.

(f) The self-employed individual is unable to provide a copy of his or her IRS Schedule SE for the preceding year showing a net profit of at least $4,600 or to certify to an average net profit of at least $1,150 per quarter since becoming self-employed or for the preceding four quarters, whichever period is less.

(g) The employing unit or self-employed individual has failed to make a return or to pay contributions within the time required, pursuant to the CUIC and there is an unpaid amount of contributions owing by the employing unit or self-employed individual.

(h) A prior elective coverage agreement under Sections 708(b) or 708.5 was terminated as seasonal in nature, for failure to file a return or pay contributions, for filing a false statement during the application process or for a conviction as outlined in paragraph (I) below within the preceding eighteen (18) month period.

(I) The employing unit or any officer or agent of or person having charge of the affairs of the employing unit, or the self-employed individual has been convicted within the preceding eight consecutive calendar quarters of any violation under Chapter 10. For the purposes of this subdivision, a plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction irrespective of whether an order granting probation or other order is made suspending the imposition of the sentence or whether sentence is imposed for execution thereof is suspended.

Elections filed under Section 708.5 are subject to verification by the Department that the individual is in fact self-employed rather than an employee of another individual or firm. If an individual filing an application for coverage under Section 708.5 as a self-employed individual has any knowledge of a prior ruling issued by this Department concerning his/her status, reference to such ruling should be made on the application form and, if possible, a copy of the ruling attached.

COST OF COVERAGE

The DIEC rate is computed each calendar year on or about November 30 to ensure program solvency. Members receive notification of the following year's premium rate, reportable "income credits," and premiums payable with their fourth quarter premium notice. You may estimate the cost of coverage using form DE 3DI-I or call the telephone number shown on the front of your application for assistance.

QUARTERLY REPORT REQUIRED

The DIEC quarterly premium notice, DE 3DI, must be filed each quarter whether or not premiums are due. This notice is normally mailed by the last day of the calendar quarter. The quarterly premium notice and premiums are due on the first day of the following calendar quarter and become delinquent if not paid on or before the last day of that month. **Failure to receive a DE 3DI does not relieve you of the responsibility to pay your premiums on time.** Submitting the DE 3DI with disability information is not a claim for benefits. Contact your local disability insurance benefit office for claim information.

REPORTABLE COMPENSATION

Any adjustment of the reportable income credits and premiums due to disability must be noted on the DE 3DI quarterly report. If you have any questions regarding computing or adjusting the premium base and premiums, contact your local Employment Tax Customer Service Office or call the Elective Coverage Unit at (916) 654-6288.

BENEFIT ELIGIBILITY

The Employment Development Department determines eligibility for disability insurance benefits pursuant to the CUIC and authorized regulations. Generally, a minimum of seven months must elapse from the commencement date of coverage before a valid claim may be filed based solely on income credits reportable under your election. Eligibility is dependent on a number of factors including: Proof of a claimant's eligibility; filing of a timely claim for benefits; filing and payment of all required reports and premiums. Weekly disability benefits are payable under elective coverage regardless of whether the claimant continues to receive any compensation from his/her business.

Benefits are based on the premiums paid during the four quarters of the base period of your claim, not on your actual earnings during those quarters. Benefits for 2002 are based on premiums paid during 2000 and 2001 which are based respectively on income you earned in 1998 and 1999.

Benefits may cover both work related and nonoccupational injuries and illnesses. For more benefit information, see the pamphlet entitled "Disability Insurance Provisions," DE 2515, or contact your local disability insurance field office.

CANCELLATION/TERMINATION OF ELECTIVE COVERAGE

A participant may cancel his/her elective coverage agreement as of January 1 of any calendar year, only if the agreement has been in effect for two complete calendar years, by filing a letter with the Department requesting termination on or before January 31 of that year.

The Department may terminate your elective coverage agreement if it is found that any of the "Conditions for Denial of Coverage" exist or you meet one of the other conditions for termination of coverage by the Department found in Section 704.1 CUIC. They are: 704.1(a)(5). The self-employed individual reports a net profit of less than $4,600 on his or her IRS Schedule SE for a third consecutive year. 704.1(a)(7) The employing unit or self-employed individual, or a representative thereof, is found to have filed a false statement in order to be considered eligible for elective coverage. You will be given written notification of the Department's termination of your elective coverage agreement and will have 30 days to file a Petition for Review of the termination of elective coverage. The termination shall not affect the liability of the self-employed individual for any premiums due, owing or unpaid to the Department. Termination by the Department may affect your ability to draw DI benefits.